

§ 417.454

42 CFR Ch. IV (10-1-06 Edition)

these services and supplemental services, which are the same as the additional benefits furnished Medicare enrollees of the HMO or CMP who are entitled to benefits under both Parts A and B, the HMO's or CMP's combined premium for both these groups of services that the Part B enrollee must pay may not exceed 95 percent of the weighted average AAPCC for Part A services (or the Medicare payment for Part A services, if it is less) for the Medicare enrollee of the HMO or CMP.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45678, Sept. 1, 1995]

§ 417.454 Charges to Medicare enrollees.

(a) *Limits on charges.* The HMO or CMP must agree to charge its Medicare enrollees only for the—

(1) Deductible and coinsurance amounts applicable to furnished covered services;

(2) Charges for noncovered services or services for which the enrollee is liable as described in § 417.452; and

(3) Services for which Medicare is not the primary payor as provided in § 417.528.

(b) *Limit on charges for inpatient hospital care.* If a Medicare enrollee who is an inpatient of a hospital requests immediate QIO review (as provided in § 417.605) of any determination by the hospital furnishing services or the HMO or CMP that the inpatient hospital services will no longer be covered, the HMO or CMP may not charge the enrollee for any inpatient care costs incurred before noon of the first working day after the QIO issues its review decision.

(c) *Reporting requirements.* A risk HMO or CMP must report, within 90 days after the end of the contract period, all premiums, enrollment fees, and other charges collected from its Medicare enrollees during that period.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 59 FR 59941, Nov. 21, 1994; 60 FR 45678, Sept. 1, 1995]

§ 417.456 Refunds to Medicare enrollees.

(a) *Definitions.* As used in this section—

Amounts incorrectly collected means amounts collected that are in excess of those specified in § 417.452. It includes amounts collected when the enrollee was believed not entitled to Medicare benefits if the enrollee is later determined to have been entitled to Medicare benefits and CMS is liable for payments as specified in § 417.450.

Other amounts due means amounts due a Medicare enrollee for services obtained outside the HMO or CMP if they were—

(1) Emergency services;

(2) Urgently needed services for which the HMO or CMP has assumed financial responsibility; or

(3) On appeal under subpart Q of this part, found to be services the enrollee was entitled to have furnished by the HMO or CMP.

(b) *Basic commitment.* An HMO or CMP must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and any other amounts due the enrollees or others on their behalf.

(c) *Refund by lump sum payment.* An HMO or CMP must make refunds to its current and former Medicare enrollees, or to others who have made payments on behalf of enrollees, by lump sum payment for the following:

(1) Incorrectly collected amounts that were not collected as premiums.

(2) Other amounts due.

(3) All amounts due, if the HMO or CMP is going out of business.

(d) *Refund by premium adjustment or lump sum payment or both.* An HMO or CMP may make refund by adjustment of future premiums, by lump sum payment, or by a combination of both methods, for amounts that were incorrectly collected in the form of premiums or through a combination of premium payments and other charges.

(e) *Refund when enrollee has died or cannot be located.* If an enrollee has died or cannot be located after reasonable effort by the HMO or CMP, the HMO or CMP must make the refund in accordance with State law.

(f) *Reduction by CMS.* If the HMO or CMP does not make refund in accordance with paragraphs (b) through (d) of this section by the end of the contract period following the contract period

during which an amount was determined to be due an enrollee, CMS reduces its payment to the HMO or CMP by the amounts incorrectly collected or otherwise due, and arranges for those amounts to be paid to the Medicare enrollee.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45678, Sept. 1, 1995]

§ 417.458 Recoupment of uncollected deductible and coinsurance amounts.

An HMO or CMP agrees not to recoup deductible and coinsurance amounts for which Medicare enrollees were liable in a previous contract period except in the following circumstances:

(a) The HMO or CMP failed to collect the deductible and coinsurance amounts during the contract period in which they were due because of—

(1) Underestimation of the actuarial value of the deductible and coinsurance amounts; or

(2) A billing error.

(b) The HMO or CMP has identified the amounts and obtained advance CMS approval of the recoupment and the method and timing of recoupment.

(c) The HMO or CMP collects these amounts no later than the end of the contract period following the contract period during which they were found to be due.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 45678, Sept. 1, 1995]

§ 417.460 Disenrollment of beneficiaries by an HMO or CMP.

(a) *General rule.* Except as provided in paragraphs (b) through (i) of this section, an HMO or CMP may not—

(1) Disenroll a Medicare beneficiary; or

(2) Orally or in writing, or by any action or inaction, request or encourage a Medicare enrollee to disenroll.

(b) *Bases for disenrollment: Overview—*(1) *Optional disenrollment.* Generally, an HMO or CMP may disenroll a Medicare enrollee if he or she—

(i) Fails to pay the required premiums or other charges;

(ii) Commits fraud or permits abuse of his or her enrollment card; or

(iii) Behaves in a manner that seriously impairs the HMO's or CMP's ability to furnish health care services to the particular enrollee or to other enrollees.

(2) *Required disenrollment.* Generally, an HMO or CMP must disenroll a Medicare enrollee if he or she—

(i) Moves out of the HMO's or CMP's geographic area;

(ii) Fails to convert to the risk provisions of the HMO's or CMP's Medicare contract;

(iii) Loses entitlement to Medicare Part B benefits; or

(iv) Dies.

(3) *Related provisions.* Specific requirements, limitations, and exceptions are set forth in paragraphs (c) through (i) of this section.

(c) *Failure to pay premiums or other charges—*(1) *Basic rule.* Except as specified in paragraph (c)(2) of this section, an HMO or CMP may disenroll a Medicare enrollee who fails to pay premiums or other charges imposed by the HMO or CMP for deductible and coinsurance amounts for which the enrollee is liable, if the HMO or CMP—

(i) Can demonstrate to CMS that it made reasonable efforts to collect the unpaid amount;

(ii) Gives the enrollee written notice of disenrollment, including an explanation of the enrollee's right to a hearing under the HMO's or CMP's grievance procedures; and

(iii) Sends the notice of disenrollment to the enrollee before it notifies CMS.

(2) *Exception.* If the enrollee fails to pay the premium for optional supplemental benefits (that is, a package of benefits that an enrollee is not required to accept), but pays the basic premium and other charges, the HMO or CMP may discontinue the optional benefits but may not disenroll the beneficiary.

(d) *Enrollee commits fraud or permits abuse of the enrollment card—*(1) *Basis for disenrollment.* An HMO or CMP may disenroll a Medicare beneficiary if the beneficiary—

(i) Knowingly provides, on the application form, fraudulent information that materially affects the beneficiary's eligibility to enroll in the HMO or CMP; or